Working Toward a Cure for Tomorrow
by Addressing Health Care Today

Given by Congressman Jerry Moran at the Kansas University School of Medicine

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I thought this would be fitting given my crowd today. A doctor calls his patient and says, "I have some bad news and some very bad news". The patient replies, "Well, might as well give me the bad news first." The doctor says, "The lab called with your test results. They said you have 24 hours to live." The patient screams, "24 hours! That's terrible! What could be worse? What's the very bad news?" And the doctor replies, "Well, they gave me your file yesterday."

Though the humor of that is a bit dry, it does underscore the difficulties our doctors, nurses and health care facilities face in this country every day, trying to manage a health care system with many difficulties and inefficiencies.

In Congress, the current focus is on Social Security. Baby Boomers - my generation - will soon begin retiring and placing tremendous strains on the solvency of the program. I do believe that this is a concern we're going to have to address. But the even bigger problem our country faces is the cost of health care. There is no greater domestic issue facing our country today.

In November of 2003, Congress passed the largest overhaul of the Medicare program since it's inception. I have heard from seniors that too often, the choice is between refilling their prescriptions, or paying their light bill. But despite my understanding of the need for assistance to buy prescriptions for those who use Medicare, I did not support this legislation. I could not justify simply spending more money - money the Medicare Trust Fund does not have - without first working to address the underlying problem of health care - the rising costs. We must treat the disease, not just the symptoms.

Annual health care spending in the United States exceeds $1.4 trillion, representing the largest sector of the nation's economy. It is by far the most expensive health care system in the world. Health care costs are increasing at a faster rate than incomes, resulting in many no longer being able to afford the care they need. Because of costs, it is estimated that Americans receive only about half the care their physicians recommend.

The reality is that costs affect access, and lack of access in turn increases costs. Whether a person is a primary care doctor, a specialist, a hospital administrator, or a patient, each makes decisions based on expenses. Hospital administrators look at the unreimbursed cost burden their facilities incur. Doctors look at the cost of malpractice insurance, and if they're in private practice, then unreimbursed costs as well. On the patient side, people with health insurance can usually go to the doctor, but they may not be able to afford the treatment the doctor recommends. For those without insurance, a doctor's appointment may be beyond the family income, and the costs of prescription drugs impossible. Without proper reimbursements, providers have less incentive to provide care. Without an adequate number of providers,

patients will not be treated, so they end up in the emergency room, or they allow a chronic condition to worsen, the treatment for which is far more expensive.

Among the driving factors of increasing costs are 1- insufficient access, 2- inadequate reimbursement, 3- antiquated information technology systems, 4- an expensive tort system, 5- inadequate preventive care, and 6- ever-increasing prescription drug costs. If we address each of these issues, we can begin the process of improving our nation's health care delivery system.

Although health care is in large part financed and regulated nationally, it is delivered locally. Kansans must have access to local hospitals and other health care providers. Having a primary care physician and a place to go for health care services, within a reasonable distance of home, is essential to all Kansans. Primary care doctors are the gateway to accessing the entire range of health care services.

For some, using the primary care physician is not an option because of an inability to pay. For these people, increasing the number of community health centers that provide primary care services will improve the delivery of health care. Although they are but one piece of the puzzle, community health centers are clearly key players. By investing in our nation's community health care centers, we take an important step forward in getting health care to those who often need it but cannot afford it. This year the President's budget recognizes the importance of CHCs and recommends the creation of 1200 new centers. This year's budget proposes a $304 million increase for CHCs, with total funding reaching $2.038 billion.

Too often individuals use the emergency room as their initial entry into the health system. The ER is the most expensive unit in the hospital, and yet it is used for routine injuries and illnesses. Community health centers, or CHCs give people a place for primary care other than the ER.

Community Health Centers manage a large caseload of uninsured patients and encourage participation in chronic disease management. Unfortunately, these centers face numerous challenges in recruiting and retaining staff. Health centers are often located in areas that do not easily attract health care professionals and it is difficult for them to offer competitive salaries. By managing chronic disease at the primary care level, patients improve their quality of life and also reduce the chance of a medical emergency. In Kansas, we have eight CHCs that serve 12 communities. They are: Pittsburg, Wichita, Junction City, Emporia, Salina, Topeka, Great Bend, Larned, Garden City, Dodge City, Liberal and Ulysses. This is a good array of communities, but we need more.

Health professionals are vital to improving overall health and wellness. Access to effective primary care physicians is a must. However, it is often not as financially attractive to be a primary care physician as it is to practice most specialties. The current reimbursement system does not reflect the true value of a primary care physician. Payment reflects procedures only and does not take into account the physician's coordination of a patient's care with specialists or other professionals. Payments are not increased if the doctor uses the latest medical information or the best technology. And payments are in no way based on results.

Coordination of care, supporting clinical decision with evidence-based guidelines, and positive patient results should all be rewarded.

One more way to help control health care costs lies in wellness and prevention. Reducing the frequency of illness and providing early diagnosis allows treatment in early stages of disease, where treatments are more effective and less costly. Through a focus on prevention, wellness, early diagnosis and treatment, Americans will earn their largest return for the dollars they invest in health care. In a health care system designed for short-term interventions for acute care problems, chronic care is extremely expensive and largely uncoordinated. To get providers to focus on prevention, there need to be reimbursement incentives.

Yet in setting up this more qualitative system, with an emphasis on prevention, coordination, and results, we cannot force more paperwork on our providers. In February I completed a visit to each of the hospitals in the First Congressional District - all 75. I have now been in each of my hospitals at least once. What I learned is that health care providers are dealing with the increasing costs of care, a growing government bureaucracy, and too much red tape.

Information on health care performance needs to be systematically available, but making it available need not be burdensome. Achieving this will require a major overhaul of our current health information systems, with a focus on automating the entry and retrieval of data. Such data can support clinical decisions and measure quality. With this automation, routine care and medications could be tracked and measured, emergencies could be documented, and information could be more easily shared with all health care professionals involved in a patient's care.

According to the American Hospital Association, for the various stages of care of a typical patient, paperwork adds at least 30 minutes to every hour of patient care provided. A huge discrepancy in our health care system is that we provide cutting edge care, yet health professionals still spend countless hours tracking care on paper. Because so much is on paper, it is difficult to keep track of information, which affects the accuracy of clinical decisions. Even simple computer systems that use electronic prescriptions in place of handwritten notes have already paid off by reducing medical errors and reducing costs.

The use of health information technology can revolutionize healthcare by creating a healthcare data system that supports electronic health records, electronic prescriptions, and clinical decision support tools. More accessible health care data will improve patient care quality and safety and will lower costs. The President has proposed including $75 million in the 2006 budget for use in developing health information technology.

Even with technology, the physician remains the key. For Kansas City residents, having a doctor nearby is a given, but in rural areas, it can be a big question mark.

Doctors who seek the highest standard of living practice in suburban areas. Compare Johnson County and Smith County, for example. In Johnson County, only 10 percent of the population is over 65 years old. But in Smith County, about 28 percent of the population is in that age range. Just in the City of Overland Park, there are eight hospitals. In Smith Center, the Smith County Memorial Hospital is the Sole Community Provider. For the over-65 age group, hospital expenses are nearly double that of other age groups. When physicians are not adequately reimbursed for Medicare patients, they do not want to practice in a place like Smith Center, with a high Medicare population. A better reimbursement system will improve universal access. Yet, if Congress does not respond, physician reimbursements from Medicare are slated to drop 31 percent from 2006 to 2013. The cost of practicing medicine is expected to climb 19 percent in the same time period. Those cuts would mean a $20,000 loss for each

Kansas physician. But more importantly, it would mean more Kansas communities without physicians.

In the past, Congress has acted to prevent cuts in reimbursements and to instead have a 1.5 percent increase in payments. Those were temporary fixes, and something more permanent must be done. Improvements in the reimbursement system would make primary care just as attractive a field as specialties and would reduce the number of counties in Kansas that are medically underserved.

Our health care professionals obviously need a place to practice, and hospitals continue to be vital components of the health care delivery system, providing care to the uninsured, even when they are not guaranteed payment for their services. The government mandates that hospitals treat every person who arrives at the emergency room door. Hospitals are also required to take Medicare payments as payment in full.

Since hospitals are not fully paid for all the care they provide, the cost of services for the uninsured gets built into prices paid by the insured. When the uninsured receive care, hospitals attempt to cover costs by shifting costs. The hospital's deficit is passed along to insured patients in the form of higher bills. Private insurance companies then pass along those increased costs in the form of higher premiums. The costs of health insurance premiums are quickly becoming out of reach for many employers and individuals alike. One more problem creating a cycle.

With a more appropriate reimbursement system and better Medicare and Medicaid policies, perhaps we could break that cycle. If so, hospitals wouldn't have to cost-shift, the insured patients wouldn't have inflated bills, and maybe, just maybe, health insurance costs would begin to plateau.

To help keep health insurance affordable, patients must have reason to care about their health care costs. Last year Congress created Health Savings Accounts, or HSAs, which give Americans tax incentives to contribute to savings accounts specifically set aside for medical expenses. As of September 2004, almost half a million insurance policies with HSAs were up and running. 30 percent of these are for people who previously had no health insurance at all.

Despite this good start, more needs to be done to make HSAs accessible. Contributions to HSAs should be tax deductible and tax credits for low-income families to purchase catastrophic plans should be available. This year, I am supporting H.R. 37, the Health Insurance Affordability Act, which would allow those with HSAs to get a tax deduction for their catastrophic plan premiums.

Health insurance needs to be affordable for employers, too. For example, General Motors currently spends about $1500 on health care, for every car it produces. No wonder we have to worry about outsourcing and foreign competition. Last year I voted for H.R. 660, the Small Business Health Fairness Act. This legislation would allow small businesses to pool their resources, to have more bargaining power, when negotiating with insurance companies. Although H.R. 660 passed the House of Representatives, it is stalled in the Senate. Similar legislation has been reintroduced this year.

Patients and employers are not the only groups struggling with insurance costs. Doctors across the United States are facing increasing malpractice insurance premiums. Even student doctors are affected by liability concerns. According to the American Medical Association, about half of students near completion of medical school factor in liability risks when deciding on which specialty to practice.

At the same time, an alarming number of doctors are abandoning their practices in response to high insurance premiums. Blue Cross/Blue Shield has collected data and reports that 56 percent of their plans report a higher number of physicians leaving practice or retiring than in the past. One-third of their plans reported that physicians are moving their practices out of states that are in a malpractice crisis. Although Kansas is not in crisis, it is considered to be showing problem signs.

Overall physician premiums in Kansas have actually fallen since their peak in 1988, just before Kansas enacted its tort reforms. The importance of liability reforms is clear when you look at malpractice premiums in California. California has enacted comprehensive malpractice reforms - more extensive than just caps on awards. As a result, malpractice premiums have only risen 167 percent over the past 25 years, as opposed to the rest of the country, where rates have risen 505 percent. On the federal level I continue to support legislation that places limits on litigation and creates guidelines for non-economic and punitive damage awards, such as H.R. 534, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act. This legislation passed the House last year, but reached an impasse in the Senate.

However, the larger effect of the malpractice system on health care costs is seen in practicing

physicians' behavior. They have reacted to the threat of malpractice lawsuits by practicing "defensive medicine." This involves administering precautionary treatments such as additional tests and prescription drugs, solely for fear of legal liability. Economists estimate that between $83 and $151 billion could be saved per year by eliminating defensive medicine practices. These precautionary measures have little benefit for the patient, but increase patients' bills. 79 percent of physicians report that they practice defensive medicine for fear of being sued.

Even with better reimbursements, better technology, and lower insurance rates, we are still left with the problem of prescription drug costs. Prescription drug expenditures remain one of fastest-growing parts of the U.S. health care system. Just this month, an AARP study found that in 2000, common brand-name drug prices increased 4.1 percent, but in 2003, they rose 6.9 percent. In 2004, the increase was 7.1 percent - that's almost three times the rate of inflation.

We must achieve cost savings on prescription drugs for all Americans. Federal agencies, such as the Department of Defense, the VA and the Indian Health Service are cutting drug costs for beneficiaries by negotiating with drug manufacturers for better prices. Legislation has been introduced in Congress that would allow Medicare to negotiate for these better prices as well. The potential for savings in a Medicare-administered benefit is great.

The prescription drug patenting process also needs attention. Brand-name drugs are usually protected by patent law for 20 years. Once that time runs out, many companies alter the drug formula slightly, get that patented, and essentially get a 20-year extension on the same prescription drug. That practice is damaging because it makes the development and marketing of generic drugs more difficult, and eliminates price competition.

Also, pharmaceutical companies continue to spend a large amount on direct to consumer advertising. Advertising not only drives up the costs of prescriptions, but also increases demand for more expensive drugs in cases when a cheaper alternative will do. Everyone will go to their doctor and say, "I want that purple pill." Pharmaceutical companies shouldn't be provided tax incentives to spend more on advertising.

Much needs to be done. The reimbursement system must reflect the way health care is today, not the way it was fifty years ago. That means recognizing the importance of coordination of care, the value of information technology, and the benefits of preventive health care. I support measures that give providers incentives to implement better technology, allowing them to more readily access the most current data and make better-informed clinical decisions.

I will continue supporting efforts to give employers better bargaining power with insurance companies, and efforts to lower malpractice premiums. Access matters. Our Kansas communities will vanish if we do not ensure that people have access to health care. People cannot take the risk of living in a community without a hospital or doctor. I recognize that, and I am committed to working will all aspects of the health care community to make sure all Kansans have access to doctors and hospitals.

Health care has been one of my top priorities while serving in Congress. Recently, I visited Emporia State University and asked some of the nursing students why they wanted to become nurses. The answers were what you would want to hear. One student said that when she was a little girl, a nurse saved her grandmother's life, so then she wanted to do the same for others. But when I speak with nurses today, and ask them about their jobs, I hear about paperwork,

bureaucracy. Government has the ability to take away the nobility, the joy, of work in health care, and it ought not be that way.

Being here today, and meeting with the next generation of doctors, nurses and surgeons only reinforces my belief in the dedication and talent of Kansas health care providers and the quality of care you provide. However, it also demonstrates the need to provide you with the tools necessary to improve the access and affordability of health care. The work that you all do saves lives, improves the quality of life, and matters to each and every one of us. Your work is far more important than anything I might do in Congress. Thank you all for having me here today. I welcome your questions and comments.